

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09382

9389

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Principio Furnace		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Principio Furnace x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Road		d. STREET ADDRESS Jackson Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eleanor J. Bourg		4. DATE OF DEATH Sept. 15 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1912
9. AGE (In years last birthday) 45		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Insurance Office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME L. Layfield Jackson		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 221-03-6000	
17. INFORMANT Alfred O. Bourg, Principio Furnace, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x Carcinoma Liver (Metastatic) 6 months DUE TO Carcinoma Breast 1 yr 8 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 10, 1956 to Sept 15, 1957, that I last saw the deceased alive on Sept 13, 1957, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson, M.D.		ADDRESS (Street, city or town, state) Post Report - St. 1657	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.		DATE SIGNED Sept 16, 1957	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 9-18-1957	22c. NAME OF CEMETERY OR CREMATORY Principio	22d. LOCATION (City, town, or county) (State) Principio Furnace, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR DATE 9-18-1957	
		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		1900-01-01		Male		White		Married		Teacher		Heart Disease		Home		1957-09-15		10:00 AM		[Signature]		[Signature]	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
New York City		1957-09-15		Male		White		Married		Teacher		Heart Disease		Home		1957-09-15		10:00 AM		[Signature]		[Signature]	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
New York City		1957-09-15		Male		White		Married		Teacher		Heart Disease		Home		1957-09-15		10:00 AM		[Signature]		[Signature]	

BUREAU V. S.

SEP 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9390

CERTIFICATE OF DEATH

09383

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2mos.4days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		d. STREET ADDRESS 5123 S. "D" Avenue, N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HORACE Middle W. Last BROWN		4. DATE OF DEATH September 28, 1957 19	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1913
9. AGE (In years lost birthday) 44 yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Board of Public Welfare, Maryland	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HORACE C. BROWN		14. MOTHER'S MAIDEN NAME ELIZABETH MATTHEWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
(If yes, give war or dates of service) WW-II		17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 572X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Glomerulonephritis, chronic. DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24, 1957 to Sept. 28, 1957, and that death occurred at 11:55AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. M. HARRIS, M.D. VA Hospital, Perry Point, Md. 9-28-57 PHYSICIAN'S NAME (Type) W. M. HARRIS, M.D., Acting Director, Professional Services.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-29-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. T. RHINES & CO., 901-3rd St., S.W., Washington, D.C.		24a. REC'D BY REGISTRAR DATE 10-1-57 1957 24b. REGISTRAR'S SIGNATURE	

RECEIVED

9376

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Warwick</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hosp Elkton Md</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Durant</i> Middle <i>H</i> Last <i>Clark</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 18 1895</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>2</i>	IF UNDER 24 HRS. Hours <i>6</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Labor</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Emerson Clark</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>daughter Mrs Kenneth Manlove</i>	
17. INFORMANT <i>daughter Mrs Kenneth Manlove</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Occlusion</i> DUE TO (c) <i>Myocardial Infarction</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Severe Anemia, Severe Emphysema</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 1</i> , 19 <i>57</i> to <i>Sept 3</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Sept 3</i> , 19 <i>57</i> , and that death occurred at <i>5:00</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Oberchain</i> M.D.		ADDRESS (Street, city or town, state) <i>Cecil, Md</i> DATE SIGNED <i>4 Sept 57</i>	
PHYSICIAN'S NAME (Type) <i>Wallace Oberchain</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/5/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lakeside Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Dover Dela</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Lester Daniels</i>		ADDRESS <i>Middletown, D.</i>	
24a. REC'D BY REGISTRAR <i>9/5/57</i>		24b. REGISTRAR'S SIGNATURE <i>JR Frazier</i>	

SEP 9 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09385

9391 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Nottingham Pa.</u>		LENGTH OF STAY (in this place) <u>39 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Nottingham, Pa.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nottingham R.D. #1 Pa.</u>				STREET ADDRESS (If rural give location) <u>1 Nottingham R.D. #1 Pa.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mrs Ollie Cockrell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>September 21, 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 21, 1871</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Edenburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Noah Mc Inturff</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Clemm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Stanley Mc Inturff Nottingham R.D. #1, Pa</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
33/x IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 2, 1957</u> to <u>Sept 21, 1957</u>, that I last saw the deceased alive on <u>Sept 21, 1957</u>, and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E.B. Robinson</u> M.D.				ADDRESS (Street, city, town, state) <u>Perkins</u> DATE SIGNED <u>Sept 21 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>9/24/57</u>	NAME OF CEMETERY OR CREMATORY <u>Friends Burial Ground</u>		LOCATION (City, town, or county) (State) <u>Calvert, Cecil Co. Md.</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>W. H. Beach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William C. Johnston</u>		ADDRESS <u>Pa.</u>		
DATE <u>SEP 23 57</u>							

RECEIVED

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9392

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keyser</u> 85 X - 3	
c. LENGTH OF STAY IN 1b <u>2mos. 24days</u>		d. STREET ADDRESS <u>112 N. Main Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>H.</u> Last <u>FORMAN</u>		4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1900</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BRUCE S. FORMAN</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE D. KILLIUS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>214 10 3663</u>	
17. INFORMANT <u>Hospital Records, VAH., Perry Point, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of myocardium due to arteriosclerotic</u> <u>420.1</u> DUE TO <u>coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 3</u> weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 26, 1957</u> , to <u>Sept. 19, 1957</u> , that he was <u>alive on</u> <u>June 26, 1957</u> and that death occurred at <u>12:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u> DATE SIGNED <u>9-19-57</u> ACTUAL SIGNATURE <u>W. Oppler</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>W. OPPLER</u> Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) <u>Oakland, Garrett Co., Md.</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u>Havre DeGrace, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>9-19-57</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09387

9377

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 142 E. High St.	
3. NAME OF DECEASED (Type or print) First Obie Middle Garrison Last		4. DATE OF DEATH Month Sept. Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1917
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Theatre	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Edward Garrison	
14. MOTHER'S MAIDEN NAME Pearl Steed		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 217-05-7630		17. INFORMANT Samuel West-114 Bell's Lane, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 DUE TO Hematemesis (Gastric hemorrhage) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Liver cirrhosis DUE TO (c) Chronic alcoholism.		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9.26, 1957, to 9.26, 1957, that I last saw the deceased alive on 9.26, 1957, and that death occurred at 7 P. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Peter Stavrakis M.D.		154 W. MAIN, ELKTON, Md. 9287	
PHYSICIAN'S NAME (Type) PETER STAVRAKIS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10/1/57	22c. NAME OF CEMETERY OR CREMATORY Pungoteague Cemetery	22d. LOCATION (City, town, or county) (State) Pungoteague, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Edmund Bell		ADDRESS 909 Poplar St., Wilm. Del.	
24a. REC'D BY REGISTRAR DATE 9/30/57		24b. REGISTRAR'S SIGNATURE JRF	

CERTIFICATE OF DEATH

Chronic alcoholism.
Liver cirrhosis
Heart disease (coronary artery disease) 15 years

BUREAU V. S.

RECEIVED

OCT 2 1957

PETER STARVANSKY M.D.

Dr. J. J. J.

Dr. J. J. J.

Dr. J. J. J.

Dr. J. J. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09388

CERTIFICATE OF DEATH

Reg. Dist. No. 96

9393

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg	
c. LENGTH OF STAY IN 1b 31 yrs. 2 mo.		d. STREET ADDRESS 5216 Tilden Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last HYSON		4. DATE OF DEATH Month September Day 6 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-00
9. AGE (In years lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Albrecht Company	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Hyson		14. MOTHER'S MAIDEN NAME Lillian Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage massive retroperitoneal, due to ruptured abdominal aorta 451X DUE TO (b) Arteriosclerosis of the abdominal aorta severe Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH 2-3 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1926, to September 6, 1957, and that death occurred at 12:45 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Perry Point, Md. DATE SIGNED 9-6-57 ACTUAL SIGNATURE E. S. Ellis, M.D. PHYSICIAN'S NAME (Type) E. S. ELLS Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-6-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Bladensburg Rd., Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Nalley's Fun.Home, Mount Rainier, Md.		24a. REC'D BY REGISTRAR DATE 9-6-57 24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

BUREAU V. S.

SEP 10 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG221 10-8-57 et

09389

CERTIFICATE OF DEATH

9378

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Elkton		LENGTH OF STAY (in this place) life		CITY (If outside corporate limits, write RURAL and give nearest town) Elkton		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 156 W. Main St.				STREET ADDRESS 156 W. Main Street			
3. NAME OF DECEASED (Type or Print) George Turner Jeffers				4. DATE OF DEATH (Month) Sept (Day) 26 (Year) 1957			
5. SEX M	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Aug 5-1880	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Dry Goods Store		11. BIRTHPLACE (State or foreign country) Elkton-Md		12. CITIZEN OF WHAT COUNTRY U.S.C.	
13. FATHER'S NAME John Herman Jeffers				14. MOTHER'S MAIDEN NAME Mary Jane Cartmell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 216-07-2003		17. INFORMANT & ADDRESS Mrs. Florence Jeffers-sister	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) Chronic myocarditis				INTERVAL BETWEEN ONSET AND DEATH about 2 yrs			
ANTECEDENT CAUSE(S) DUE TO (B) general arterio-sclerosis				unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) with mental deterioration				month plus			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-3-57, 1957, to 9-26-1956, that I last saw the deceased alive on 9-23-1957, and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
SIGNATURE V. H. Mc Knight				ADDRESS (Street, city, town, state) Elkton - Maryland		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/29/57		NAME OF CEMETERY OR CREMATORY Elkton Cemetery		LOCATION (City, town, or county) (State) Elkton Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE F. R. Frazier		25. FUNERAL DIRECTOR'S SIGNATURE H. Walter Boxer		ADDRESS Elkton Md	
DATE 9/30/57							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Form No. 1

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Race

7. Occupation

8. Cause of death

9. Date of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial place

19. Signature of interment

20. Signature of record

21. Signature of office

22. Signature of department

23. Signature of state

24. Signature of federal

25. Signature of international

26. Signature of world

27. Signature of universe

28. Signature of everything

29. Signature of all

30. Signature of nothing

31. Signature of someone

32. Signature of no one

33. Signature of everybody

34. Signature of nobody

35. Signature of almost everybody

36. Signature of almost nobody

37. Signature of quite a few people

38. Signature of not too many people

39. Signature of a lot of people

40. Signature of a great many people

41. Signature of a whole lot of people

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 9394 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

09390

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY York			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) York 75x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 503 Walnut Street			
3. NAME OF DECEASED (Type or print) First ROY Middle E. Last KRIECHBAUM				4. DATE OF DEATH Month September Day 15 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-2-82	
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Clerk				10b. KIND OF BUSINESS OR INDUSTRY Post Office Dept.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Casimer Kriechbaum				14. MOTHER'S MAIDEN NAME Lucy Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-I unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 Bronchopneumonia bilateral unresolved, following operation DUE TO (b) Insertion of Crutchfield Tongs (9-6-57) DUE TO (c) Fracture closed of odontoid process of second cervical vertebra, due to alleged fall at home CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (c), STATING THE UNDERLYING CAUSE LOST.							INTERVAL BETWEEN ONSET AND DEATH 5 to 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease, severe							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 5, 19 57, to September 15, 19 57, and that death occurred at 12:00 noon, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. M. Harris for				ADDRESS (Street, city or town, state) VAH, Perry Point, Md.		DATE SIGNED 9-17-57	
PHYSICIAN'S NAME (Type) W. OPPLER				Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-16-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Baltimore de Grace, Md.				24a. REC'D BY REGISTRAR DATE 9-19-57		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

RECEIVED

SEP 23 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09391

9379

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>New Castle</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton,</u>			c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Ellsmere 46 X-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital. D.O.A.</u>				d. STREET ADDRESS <u>116 Western Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nicholas Joseph Lannan</u>				4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-1872</u>	
9. AGE (In years last birthday) <u>84 yrs.</u>		IF UNDER 1 YEAR Months <u>84</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist General</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wilmington, Del.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Hewson E. Lannan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cecilia Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Annis E, Lannan.</u> Address <u>Ellsmere, Del. 116 Western Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9-2-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington, Delaware</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pippin</u> ADDRESS <u>Elkton Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>FR Frazier</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 2 1957

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09392

9395

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Becil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Georgia b. COUNTY Bibb	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 5 yrs. 11 mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Macon 49x-3		d. STREET ADDRESS 947 Jordan Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LUTHER Middle N. Last LAWSON		4. DATE OF DEATH Month September Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-17
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 40 Hours 40 Min. 40	IF UNDER 24 HRS. Months 40 Days 40 Hours 40 Min. 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker		10b. KIND OF BUSINESS OR INDUSTRY Textile Mill	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 256 26 8533	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculosis, pulmonary, bilateral, far advanced unknown DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10 , 19 51 , to September 10 19 57 , and that death occurred at 3:13a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 9-11-57 ACTUAL SIGNATURE W. Oppler M.D. PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 9-11-57	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Macon, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Harry de Grace, Md.		24a. REC'D BY REGISTRAR DATE 9-12-57	
24b. REGISTRAR'S SIGNATURE James E. Daugherty			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF NEXT OF KIN [Faint text]		SIGNATURE OF BURIAL OFFICIAL [Faint text]		SIGNATURE OF FUNERAL HOME [Faint text]	
SIGNATURE OF CHURCH OFFICIAL [Faint text]		SIGNATURE OF CEMETERY OFFICIAL [Faint text]		SIGNATURE OF OTHER OFFICIAL [Faint text]	

BUREAU V. S.

SEP. 13. 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09393

9396

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City, R.D.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hacks Point</u> X/			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Parsons</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-1891</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Cochranville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Edward Long</u>				14. MOTHER'S MAIDEN NAME <u>Sadie E. Nowlin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-16-1303</u>		17. INFORMANT <u>Elizabeth Carpenter, Newport, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smothered</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Well caved in</u> (c) <u> </u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was digging well and wall caved in on him</u>					
20c. TIME OF INJURY Month, Day, Year <u>8.40</u> <u>926-57</u> p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) (County) (State) <u>Chesapeake City Cecil Md.</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>9-27-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Sept 30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Kenneth Square Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hemmick</u>				24a. REC'D BY REGISTRAR <u>9/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Ralph Shivers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09394

9380

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 26 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.				d. STREET ADDRESS 226 W. High St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary C. Loomis				4. DATE OF DEATH Month Day Year September 30 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1885	
9. AGE (In years lost birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tobias Ashby				14. MOTHER'S MAIDEN NAME Minnie Shaffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. William L. Loomis		Address 226 W. High St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V disease (c) unknown INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 hours unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arthritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 30, 1957, to Sept. 30, 1957, that I last saw the deceased alive on Sept. 30, 1957, and that death occurred at 11:40a M., from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) 233 E. Main Street		DATE SIGNED 9/30/57	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pizzani				ADDRESS Elkton, Md		24a. REC'D BY REGISTRAR DATE 10/2/57	
						24b. REGISTRAR'S SIGNATURE H. J. Jagan	

CERTIFICATE OF DEATH

Page 2 of 2

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12-5-21-21	
5. PLACE OF BIRTH Memphis, Tenn.		6. OCCUPATION None	
7. MARITAL STATUS Single		8. RACE White	
9. RELIGION None		10. EDUCATION High School	
11. SOCIAL SECURITY NUMBER [REDACTED]		12. MANNER OF DEATH Suicide	
13. CAUSE OF DEATH Self-inflicted gunshot wound		14. PLACE OF DEATH Baltimore, Md.	
15. DATE OF DEATH 4-4-68		16. TIME OF DEATH 11:00 AM	
17. SIGNATURE OF PHYSICIAN [REDACTED]		18. SIGNATURE OF REGISTRAR [REDACTED]	
19. SIGNATURE OF WITNESS [REDACTED]		20. SIGNATURE OF DECEASED [REDACTED]	

BUREAU V. 4

APR 3 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09395

9397

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 22yrs7mos12days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Chestertown 14 37.2		d. STREET ADDRESS 403 W. High	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OSCAR W. LYNCH		4. DATE OF DEATH Month Day Year September 3 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1887
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Potts Lynch		14. MOTHER'S MAIDEN NAME Mattie Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 193X DUE TO Brain Tumor metastatic right hemisphere malignant Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) origin uncertain DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 3 to 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 22, 1935 , to September 3, 1957 , and that death occurred on September 3, 1957 and that death occurred at 1:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Perry Point, Md. DATE SIGNED 9-4-57			
ACTUAL SIGNATURE W. Oppler M.D.			
PHYSICIAN'S NAME (Type) W. OPPLER M.D. Director Professional Services VAH Perry Point, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-4-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE PEARLINGTON & SON		24a. REC'D BY REGISTRAR DATE 9-6-57	
24b. REGISTRAR'S SIGNATURE Dwight E. Doughty			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

SEP 9 1957

RECEIVED

9381

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elkton, Maryland Union Hosp</u>				d. STREET ADDRESS <u>George St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry D. Mewhirter</u>				4. DATE OF DEATH Month Day Year <u>9 2 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>214-20-4354</u>		17. INFORMANT <u>Bettye M. Thomas, New Castle, Delaware</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> 570.2 DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> DUE TO (c) <u>Severe Diabetes mellitus, senility</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>57</u> , to <u>Sept 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Oberstain</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u>			
DATE SIGNED <u>4 Sep 57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake City Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter du Bois</u>				ADDRESS <u>Elkton Md.</u>		24a. REC'D BY REGISTRAR <u>9/6/57</u>	
24b. REGISTRAR'S SIGNATURE <u>JR Frazier</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form No. 10

BUREAU V. 3

SEP 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09397

9398

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Fayette	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 29yrs. 4mo. 4days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Masontown 75 x -3	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle P. Last O'LAUGHLIN		4. DATE OF DEATH Month September Day 23 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-96
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael O'Laughlin		14. MOTHER'S MAIDEN NAME Nora Joyce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Bronchopneumonia, bilateral, unresolved DUE TO (b) Arteriosclerotic heart disease, moderately severe DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis general, moderately severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1928, to September 23, 1957, and that death occurred at 3:20a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler M.D.		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 9-24-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 9-24-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 9-25-57	
		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

SEP 27 1957

BUREAU V. 8

SEP 27 1957

RECEIVED

9399

CERTIFICATE OF DEATH

Reg. Dist. No. 98

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rd				c. LENGTH OF STAY IN 1b 11 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Francis Last Owens				4. DATE OF DEATH Month Sept Day 16 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 25 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Conductor, Ret. Penna R.R.			10b. KIND OF BUSINESS OR INDUSTRY Delaware		11. BIRTHPLACE (State or foreign country) USA		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Edwin Owens				
14. MOTHER'S MAIDEN NAME Seena White			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. PRB A 412094			17. INFORMANT Mrs William F. Owens North East Rd, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 10 , 19 53 , to 9-15-57 , 19 57 , that I last saw the deceased alive on 9-15-1957 , 19 57 , and that death occurred at 4:50 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 9-17-57							
ACTUAL SIGNATURE R.C. Dodson M.D.							
PHYSICIAN'S NAME (Type) R.C. Dodson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-19-1957	22c. NAME OF CEMETERY OR CREMATORY Zion Presby.		22d. LOCATION (City, town, or county) (State) North East Rural Cecil, Md			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Smith ADDRESS North East, Maryland				24a. REC'D BY REGISTRAR DATE 9-19-57	24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Local

Married

Male

White

11 years

2-11-1946

1946

White

Male

2-11-1946

BUREAU V. 5

SEP 23 1957

RECEIVED

9400

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON Rural</i>		c. LENGTH OF STAY IN 1b <i>30 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Elkton Rural</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Bell</i> Last <i>Reed</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>1</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/11/1875</i>
9. AGE (In years lost birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own Home Beach Bottom Pa.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Coleman</i>		14. MOTHER'S MAIDEN NAME <i>Bell Campbell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>None</i>	
17. INFORMANT <i>Elmer Reed-Rising Sun Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage.</i> DUE TO <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>the 19</i> , 19 <i>57</i> , to <i>Sept 1</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Sept 1</i> , 19 <i>57</i> , and that death occurred at <i>8:15</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Oneford H. Spruick</i> M.D.		ADDRESS (Street, city or town, state) <i>900 St. Rd</i> DATE SIGNED <i>Sept 2-1957</i>	
PHYSICIAN'S NAME (Type) <i>J. Earl Tyson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 4, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fairfield Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Beach Bottom Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Earl Tyson</i>		24a. REC'D BY REGISTRAR <i>J. R. Tyson</i> DATE <i>SEP 4 1957</i>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09400

9382

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle Walter Last Sapp				4. DATE OF DEATH Month September Day 19 Year 19 57			
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 21, 1898		9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter Sapp				14. MOTHER'S MAIDEN NAME Orrie Scuisse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Clarence M. Sapp Middletown, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO with cardiac hypertrophy and failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 17, 19 57 to Sept. 19 57 , that I last saw the deceased alive on Sept. 19 57 , and that death occurred at 8:35 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D.				ADDRESS (Street, city or town, state) 233 E. Main Street		DATE SIGNED 9/20/57	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-1957		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bishops Corner Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Peppin				ADDRESS 259 E. Main St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE 9/21/57	
				24b. REGISTRAR'S SIGNATURE JR. J. J. J.			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

SEP 23 1951

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9383

CERTIFICATE OF DEATH

09401

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
3. NAME OF DECEASED (Type or print) First Henry Middle M Last Snyder		4. DATE OF DEATH Month Sept. Day 13 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer		10b. KIND OF BUSINESS OR INDUSTRY Furniture Self Employed	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Snyder		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Harriet A. Snyder		Address North East, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Sept., 1957 , to 13 Sept., 1957 , that I last saw the deceased alive on 13 Sept., 1957 , and that death occurred at 9 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner		DATE SIGNED 13 Sept '57	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) North East, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-17-1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Pruitt		ADDRESS North East, Maryland	
24a. REC'D BY REGISTRAR DATE 9/16/57		24b. REGISTRAR'S SIGNATURE JR Fraser	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE THIS IN

PRINTED

1957

Death Date

1957

1957

May 3, 1957

Male

Self

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BUREAU V. S.

SEP 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09402

Reg. Dist. No. 97

9384

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 minutes 21 Elkton, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 121 W. Main St.	
3. NAME OF DECEASED (Type or print) First Middle Last James Ellis Stanley		4. DATE OF DEATH Month 9 Day 3 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-1934
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Marine		10b. KIND OF BUSINESS OR INDUSTRY Marine	11. BIRTHPLACE (State or foreign country) Elkton, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arthur F. Stanley	
14. MOTHER'S MAIDEN NAME Helen M. Mahan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes Korean	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Helen M. Stanley, 121W. Main St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Right femur, right shoulder, 823x DUE TO roof of mouth, right maxilla, cerebral Conditions, if any, which gave rise to immediate cause (b) DUE TO hemorrhage laceration face and left leg. (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit an abutment with his car	
20c. TIME OF INJURY Month, Day, Year 12, 9, 57 9 31 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 7		20f. (City or town) Elkton, R.D. Cecil Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-3-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-5-57	22c. NAME OF CEMETERY OR CREMATORY ELKTON CEMETERY	22d. LOCATION (City, town, or county) ELKTON Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Henry Pizzari		ADDRESS ELKTON, Md.	
24a. REC'D BY REGISTRAR DATE 9/3/57		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09403

9385

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>Canal St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bobby</u> Middle <u>Boy</u> Last <u>Stevens</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6, 1957</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert L. Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>Robert Stevens</u>	
17. INFORMANT <u>Chesapeake City</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> <u>Chesapeake City</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>one hour</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 6, 1957</u> to <u>Sept 6, 1957</u> that I last saw the deceased alive on <u>Sept 6, 1957</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. H. Sprecher</u> M.D.		DATE SIGNED <u>Sept 7, 1957</u>	
PHYSICIAN'S NAME (Type) <u>M. H. Sprecher</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>ELKTON Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter de Boreja</u>		ADDRESS <u>ELKTON, Md.</u>	
24a. REC'D BY REGISTRAR <u>DR Frazier</u>		24b. REGISTRAR'S SIGNATURE <u>DR Frazier</u>	

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22

BUREAU V. S.

SEP 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1181890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Del. b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Passing Through				d. STREET ADDRESS 1121 Pleasant Street			
3. NAME OF DECEASED (Type or print) First Herman Middle Stevens Last				4. DATE OF DEATH Month 9 Day 28 Year 1957			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-31-1928		9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months 28 Days	IF UNDER 24 HRS. Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10b. KIND OF BUSINESS OR INDUSTRY General Construction		11. BIRTHPLACE (State or foreign country) Kenton, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Virginia Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 221-16-5332		17. INFORMANT Ida Stevens, Kenton, Del. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Neck, Lacerated head and face and DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of tibia and fibula left ankle (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car he was in hit a tree					
20c. TIME OF INJURY Month, Day, Year 7-15 2:25 9 28 1957		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road into town of Warwick		20f. (City or town) Cecil (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9-28-57			
22a. BURIAL-CREATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-57		22c. NAME OF CEMETERY OR CREMATORY Lockwood Cem.		22d. LOCATION (City, town, or county) Hartley, Delaware (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edw R Bell ADDRESS 909 Poplar St. Wilmington Del.				24a. REC'D BY REGISTRAR 10/7/57		24b. REGISTRAR'S SIGNATURE Mrs Ralph Lees	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the date and time of execution. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING ISLANDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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BUREAU V. 3

OCT 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9402

CERTIFICATE OF DEATH

09404

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last STOKES		4. DATE OF DEATH Month September Day 18 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-92
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Forest Hills, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stokes - Deceased		14. MOTHER'S MAIDEN NAME Lilly Carter - Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ileus paralytic, following operation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic aneurism of the right iliac artery DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15-20 minutes unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized - unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from September 6, 1957 to September 18, 1957 , that death occurred on September 18, 1957 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Ceyler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. OPLER		DATE SIGNED 9-19-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-19-57	
22c. NAME OF CEMETERY OR CREMATORY Rock Spring		22d. LOCATION (City, town, or county) (State) Forest Hill, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Foster Funeral Home		ADDRESS Bel Air, Md.	
24a. REC'D BY REGISTRAR SEP 23 1957		24b. REGISTRAR'S SIGNATURE James Dougherty	

BUREAU V. 8

SEP 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09405
92

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louis B Ullary				4. DATE OF DEATH Month 9 Day 13 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-1888		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 13 Days 13	IF UNDER 24 HRS. Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) North East, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Ullary				14. MOTHER'S MAIDEN NAME Annie McKee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-07-9744		17. INFORMANT Address Mrs. Ida R. Ullary, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4343 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE P. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) P. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9-24-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-57		22c. NAME OF CEMETERY OR CREMATORY Methodist, Harts		22d. LOCATION (City, town, or county) (State) North East, Cecil, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Givens North East, Maryland				24a. REC'D BY REGISTRAR DATE 9/16/57		24b. REGISTRAR'S SIGNATURE J. R. Trager	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 18 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9387

CERTIFICATE OF DEATH

09406

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D.#2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS Corb-Ray Farm		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mabelle Middle J. Last VANSANT				4. DATE OF DEATH Month Sept. Day 17 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 9, 1893		9. AGE (In years lost birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander D. Short				14. MOTHER'S MAIDEN NAME Clara Simmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. P. C. VanSant Elkton, Md. R.D.#2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260x DUE TO Acute Cholecystitis & Cholelithiasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Diabetes Mellitis (c) 5 yrs +							INTERVAL BETWEEN ONSET AND DEATH 14 Hrs 3 days 5 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 14 Sept , 19 57 , to 18 Sept , 19 57 , that I last saw the deceased alive on 18 Sept , 19 57 , and that death occurred at 7:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED 9/18/57							
ACTUAL SIGNATURE George M. [Signature]				PHYSICIAN'S NAME (Type) Elkton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 20/57		22c. NAME OF CEMETERY OR CREMATORY Head Christiana Cemetery		22d. LOCATION (City, town, or county) (State) Newark Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				24a. REC'D BY REGISTRAR 105 Stockton St. Elkton, Md.		24b. REGISTRAR'S SIGNATURE FR [Signature]	

CERTIFICATE OF DEATH

1957

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09407

9403

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 17yrs.4mo.6days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 0210.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 196 Prince George Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last RICHARD O. WELCH				4. DATE OF DEATH September 9 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-8-95		9. AGE (In years last birthday) yrs. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Welch				14. MOTHER'S MAIDEN NAME Susan Ogle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Bronchopneumonia bilateral unresolved DUE TO (b) Arteriosclerotic heart disease severe DUE TO (c) Arteriosclerosis generalized CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema bilateral severe - unknown							INTERVAL BETWEEN ONSET AND DEATH 3-4 days unknown unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3, 1940, to September 9, 1957, that I last saw the deceased on September 9, 1957, and that death occurred at 2:01 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. Oppler M.D. V.A. Hospital, Perry Point, Md. 9-11-57 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-10-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pennington & Son, Harre de Grace, Md.				24a. REC'D BY REGISTRAR DATE Sept 13-57		24b. REGISTRAR'S SIGNATURE Irene E. Waughast	

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1957

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09408
Reg. Dist. No.

9338

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 3 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 226 East Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Willis				4. DATE OF DEATH Month Sept. Day 3 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY New Jersey	
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME No record				14. MOTHER'S MAIDEN NAME Evelyn Colkin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Gertrude M. Robinson 226 E. Main St.			
17. INFORMANT Elkton, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension, severe DUE TO (c) unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 24, 1957 , to Sept. 3, 1957 , that I last saw the deceased alive on Sept. 3, 1957 , and that death occurred at 3:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) 233 East Main Street DATE SIGNED 9/3/57			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/6/1957			
22c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.				22d. LOCATION (City, town, or county) (State) Newark, Delaware			
23. FUNERAL DIRECTOR'S SIGNATURE R. T. Jones				ADDRESS Newark, Del.			
24a. REC'D BY REGISTRAR 9/5/57				24b. REGISTRAR'S SIGNATURE J. P. Frazer			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John		Male		3 Yrs		1907	
Place of Birth		Race		Color		Date of Birth	
Maryland		White		White		1904	
Place of Death		Cause of Death		Manner of Death		Date of Death	
Maryland		Diphtheria		Natural		1907	
Place of Burial		Name of Burial Place		Name of Minister		Date of Burial	
Maryland		St. John's Church		Rev. J. H. Smith		1907	
Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Burial Place	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9404

CERTIFICATE OF DEATH

09409

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 5607 Durbin Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Roy Last Woods		4. DATE OF DEATH Month September Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Veterans Administration	
11. BIRTHPLACE (State or foreign country) Nashua, N.H.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin S. Woods		14. MOTHER'S MAIDEN NAME Jennie MacIntyre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Lobar pneumonia, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO (c) Arteriosclerosis general severe		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 14, 1957, to September 19, 1957, that I attended the deceased alive on September 18, 1957, and that death occurred at 5:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. Oppler M.D. V.A. Hospital, Perry Point, Md. 9-20-57 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-20-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE 9-21-57	
24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

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